DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To: DME Providers
Pharmacists
Home Health Agencies
Managed Care Plans
Regional Administrators
CSO Administrators

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For More Information, call:
1-800-562-6188

From: Douglas Porter, Assistant Secretary
Medical Assistance Administration

Subject: **Updates to the Nondurable Medical Supplies and Equipment (MSE) Billing Instructions**

The purpose of this memorandum is to provide providers with updates to billing instructions due to revisions to WAC 388-543-1000 and 2200. Please note changes in billing policy/procedures and definitions of terms used in MAA's Nondurable Medical Supplies and Equipment (MSE) Billing Instructions.

What are the updates?

Billing Policy/Procedure Changes

- **Effective for dates of service on and after November 1, 2002**, MAA will require:

  ✓ Valid ICD-9-CM codes on all billings. MAA will no longer allow the use of unspecified diagnosis codes such as V58.9;

  ✓ Written requests for prior authorization must be submitted to MAA on a HCFA-1500 claim form with the date of service left blank and a copy of the prescription attached.

- MAA added the words: "Included in nursing facility daily rate" to the description for procedure code A4258 in the fee schedule.

Definition Changes

- MAA has updated the definitions for "Fee-for-Service" and "Limitation Extension."

Attached are replacement pages A.1/A.2, E.1/E.2, G.3/G.4, and I.3/I.4 for MAA's Nondurable Medical Supplies and Equipment (MSE) Billing Instructions, dated February 2002, reflecting the above updates.

To obtain MAA's Billing Instructions and/or Numbered Memorandums electronically, go to: http://maa.dshs.wa.gov (click on the Provider Publications/Fee Schedules link).

Definitions

This section defines terms, abbreviations, and acronyms used in this billing instruction.

Base Year – The year of the data source used in calculating prices. [WAC 388-543-1000]

By Report (BR) – A method of reimbursement for covered items, procedures, and services for which the department has no set maximum allowable fees. [WAC 388-543-1000]

Client - An applicant for, or recipient of, DSHS medical care programs.

Code of Federal Regulations (CFR) - A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Community Services Office (CSO) - An office of the department that administers social and health services at the community level. [WAC 388-500-0005]

Core Provider Agreement - The basic contract that MAA holds with providers serving MAA clients. The provider agreement outlines and defines terms of participation in Medical Assistance.

Date of Delivery – The date the client actually took physical possession of an item or equipment. [WAC 388-543-1000]

Department - The state Department of Social and Health Services [DSHS]. [WAC 388-500-0005]

Disposable Supplies – Supplies that may be used once, or more than once, but are time limited. [WAC 388-543-1000]

Durable Medical Equipment (DME) – Equipment that:

- Can withstand repeated use;
- Is primarily and customarily used to serve a medical purpose;
- Generally is not useful to a person in the absence of illness or injury; and
- Is appropriate for use in the client's place of residence. [WAC 388-543-1000]

Expedited Prior Authorization – The process for obtaining authorization for selected durable medical equipment, and related supplies, prosthetics, orthotics, medical supplies and related services, in which providers use a set of numeric codes to indicate to MAA which acceptable indications/conditions/MAA-defined criteria are applicable to a particular request for DME authorization. [WAC 388-543-1000]

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medicare Benefits (EOMB) – A federal report generated for Medicare providers displaying transaction information regarding Medicare claims processing and payments.

Fee-for-Service – The general payment method MAA uses to reimburse for covered medical services provided to clients, except those services covered under MAA's prepaid managed care programs. [WAC 388-543-1000]

Health Care Financing Administration Common Procedure Coding System (HCPCS) – A coding system established by the Health Care Financing Administration to define services and procedures. [WAC 388-543-1000]

Healthy Options – The name of the Washington State, Medical Assistance Administration's managed care program.

Limitation Extension – A process for requesting and approving covered services and reimbursement that exceeds a coverage limitation (quantity, frequency, or duration) set in WAC, billing instructions, or numbered memoranda. Limitation extensions require prior authorization. [WAC 388-543-1000]

Managed Care - A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services. [WAC 388-538-050]

Maximum Allowable - The maximum dollar amount that MAA will reimburse a provider for specific services, supplies, and equipment.

Medicaid - The state and federally funded aid program that covers the Categorically Needy (CNP) and Medically Needy (MNP) programs.

Medical Assistance Administration (MAA) - The administration within DSHS authorized by the secretary to administer the acute care portion of the Title XIX Medicaid, Title XXI Children's Health Insurance Program (CHIP), and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Medical Identification card(s) – Medical Identification cards are the forms DSHS uses to identify clients of medical programs. These cards are good only for the dates printed on them. Clients will receive a Medical Identification card in the mail each month they are eligible. These cards are also known as DSHS Medical ID cards and were formerly called MAID cards or medical coupons.

Medically Necessary - A term for describing [a] requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

Medical Supplies – Supplies that are:

- Primarily and customarily used to service a medical purpose; and
- Generally not useful to a person in the absence of illness or injury.

[WAC 388-543-1000]

Authorization

What is prior authorization?

Prior authorization (PA) is MAA's approval for certain medical services, equipment, or supplies, before the services are provided to clients, as a precondition for provider reimbursement. **Expedited prior authorization (EPA) and limitation extensions are forms of prior authorization.**

Which items and services require prior authorization?

[Refer to WAC 388-543-1600 and 2800]

MAA bases its determination about which MSE and related services require PA or EPA on utilization criteria. MAA considers all of the following when establishing utilization criteria:

- High cost;
- Potential for utilization abuse;
- Narrow therapeutic indication; and
- Safety.

MAA requires providers to obtain PA for the following:

- Certain By Report (BR) MSE as specified in these billing instructions;
- Blood glucose monitors requiring special features;
- Decubitus care products and supplies;
- Other MSE not specifically listed in these billing instructions and submitted as a miscellaneous procedure code; and
- Limitation extensions.

MAA requires providers to obtain PA for the following items and services when the client fails to meet the expedited prior authorization criteria in these billing instructions (see "*What is expedited prior authorization?*" on page E.4). This includes, but is not limited to, the following:

- Hydrophilic catheters; and
- Diaper doublers.

General Policies for Prior Authorization

[Refer to WAC 388-543-1800]

- For PA requests, MAA requires the prescribing provider to furnish patient-specific justification for base equipment and each requested line item accessory or modification as identified by the manufacturer as a separate charge. MAA does not accept general standards of care or industry standards for generalized equipment as justification.

- When MAA receives an initial request for PA, the prescription(s) for those items or services cannot be older than three months from the date MAA receives the request.

- MAA requires certain information from providers in order to prior authorize the purchase or rental of equipment. This information includes, but is not limited to, the following:

  - ✓ The manufacturer's name;
  - ✓ The equipment model and serial number;
  - ✓ A detailed description of the item; and
  - ✓ Any modifications required, including the product or accessory number as shown in the manufacturer's catalog.

- MAA authorizes BR items that require PA and are listed in the *Fee Schedule* only if medical necessity is established and the provider furnishes all of the following information to MAA:

  - ✓ A detailed description of the item or service to be provided;
  - ✓ The cost or charge for the item;
  - ✓ A copy of the manufacturer's invoice, price list or catalog with the product description for the item being provided; and
  - ✓ A detailed explanation of how the requested item differs from an already existing code description.

- A provider may resubmit a request for PA for an item or service that MAA has denied. MAA requires the provider to include new documentation that is relevant to the request.

- If a provider does not obtain prior authorization, MAA will deny the billing, and the client must not be held financially responsible for the service.

☞ **Note:** Written requests for prior authorization must be submitted to MAA on a HCFA-1500 claim form with the date of service left blank and a copy of the prescription attached.

Procedure Code	Description	Maximum Allowable Effective 07/01/02

☞ **Billing provision limited to one (1) month's supply.**

BLOOD MONITORING/TESTING SUPPLIES

A4253	Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips. Included in nursing facility daily rate. **Modifier ZX or KS required**.	$34.63
A4254	Replacement battery, any type, for use with medically necessary home blood glucose monitor owned by patient, each. **One (1) allowed per client every 3 months.**	$6.55
A4256	Normal, low and high calibrator solution/chips. Included in nursing facility daily rate.	$11.39
A4258	Spring-powered device for lancet, each. **One (1) allowed per client every 6 months.** Included in nursing facility daily rate.	$17.96
A4259	Lancets, per box of 100. Included in nursing facility daily rate. **Modifier ZX or KS required.**	$12.68

PREGNANCY-RELATED TESTING KITS AND NURSING EQUIPMENT SUPPLIES

0178A	Pregnancy testing kit, 1 test per kit. **Not allowed for clients enrolled in the Family Planning Only or TAKE CHARGE programs.**	$10.52
0181A	Breast pump kit for electric breast pump. Purchase only.	$37.92

ANTISEPTICS AND GERMICIDES

A4244	Alcohol or peroxide, per pint. Included in nursing facility daily rate. **Maximum of one (1) pint allowed per client per 6 months.**	$0.76
A4245	Alcohol wipes, per box (of 200). Included in nursing facility daily rate. **Maximum of one (1) box allowed per client per month.**	$2.30
A4246	Betadine or pHisoHex solution, per pint. Included in nursing facility daily rate. **Maximum of one (1) pint allowed per client per month.**	$3.03

Procedure Code	Description	Maximum Allowable Effective 07/01/02
	☞ **Billing provision limited to one (1) month's supply.**	
A4247	Betadine or iodine swabs/wipes, per box (of 100). Included in nursing facility daily rate. **Maximum of one (1) box allowed per client per month.**	$4.72
0157A	Disinfectant spray, 12 oz. Included in nursing facility daily rate. **Maximum of one (1) allowed per client per 6 months.**	$4.30

10. **Is Patient's Condition Related To**: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and MAA pays as payor of last resort.

11a. **Insured's Date of Birth**: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

11b. **Employer's Name or School Name**: Primary insurance. When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name**: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. If **11d.** is left blank, the claim may be processed and denied in error.

17. **Name of Referring Physician or Other Source**: When applicable, enter the referring physician or Primary Care Case Manager name.

17a. **I.D. Number of Referring Physician**: When applicable, 1) enter the seven-digit, MAA-assigned identification number of the provider who *referred or ordered* the medical service; OR 2) when the Primary Care Case Manager (PCCM) referred the service, enter his/her seven-digit identification number here. If the client is enrolled in a PCCM plan and the PCCM referral number is not in this field when you bill MAA, the claim will be denied.

19. **Reserved For Local Use**: When applicable, enter indicator **B** to indicate *Baby on Parent's PIC*. Please specify *twin A or B, triplet A, B, or C* here.

21. **Diagnosis or Nature of Illness or Injury**: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4. A valid ICD-9-CM code will be required. MAA no longer allows the use of an unspecified/ dummy diagnosis code such as V58.9.

22. **Medicaid Resubmission**: When applicable. If the billing is resubmitted beyond the 365-day billing time limit, you must enter the ICN to verify that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.)

23. **Prior Authorization/EPA Number**: When applicable. If the service or equipment you are billing for requires authorization, enter the nine-digit number assigned to you. Use only one authorization number per claim.

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

MAA does not accept "continued" claim forms. Each claim form must be totaled separately.

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., November 4, 2002 = 110402). **Do not use slashes, dashes, or hyphens to separate month, day, year.**

24B. **Place of Service**: Required. These are the only appropriate code(s) for this billing instruction:

Code Number	To Be Used For
4	Client's residence
7	Nursing facility (formerly ICF)
8	Nursing facility (formerly SNF)
9	Other

24C. **Type of Service**: Required. Enter a **9**.

24D. **Procedures, Services or Supplies HCPCS**: Required. Enter the appropriate Centers for Medicare and Medicaid (CMS) (formerly known as HCFA) Common Procedure Coding System (HCPCS) or state-unique procedure code for the services being billed. **MODIFIER:** When appropriate enter a modifier.

24E. **Diagnosis Code**: Required. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM. A valid ICD-9-CM code is required. MAA no longer allows the use of an unspecified/dummy diagnosis code such as V58.9.